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Hysterectomy without Pedicle

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HYSTERECTOMY WITHOUT PEDICLE.[1]

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That some more radical treatment of uterine fibroids is earnestly demanded by the profession is, I believe, well recognized by the prominent leaders and journals, both at home and abroad. Formerly the profession were content with treating symptoms as they arose, with the best means that could be devised. The patient was told, and it was generally accepted by conscientious workers, that the disease was almost never fatal, and that after the menopause nature kindly arrested the growth and in a majority of cases quietly and unconsciously removed it by absorption.

The growth was considered benign, with but little, if any, danger of becoming otherwise. Notwithstanding the exhausting hæmorrhages, suffering from pain and impairment of function of important vital organs, like the stomach, lungs and heart and even kidneys, so called "Conservative Surgery" counseled waiting and forbade anything looking to a radical operation for removal of the offending growth. It had, by common consent, become almost a generally accepted proposition that fibroid tumors never proved fatal, and the principle of treatment was to ameliorate the symptoms as far as possible and await the "turn of life." For a time the treatment by ergot was the prevailing one and thousands of women suffered from this most nauseating and offensive drug. The result was, as a rule, very unsatisfactory, to say the least. The patients generally suffered more in nutrition than they gained in relief to symptoms. In the majority of cases the hæmorrhage was not even checked.

The first surgical method that proved beneficial was a thorough curetting, and this when carefully done, together with cleansing the cavity with the sublimate solution and the application of pure carbolic acid, gave permanent relief to the fearful loss of blood, in quite a large percentage of cases. But even this failed in so many instances, that the numerous abdominal surgeons one by one began to adopt the more radical operation of hysterectomy. Keith

[1] Read before the American Medical Association, June, 1892.

was among the most prominent who attempted this bold procedure, and in a list of thirty-eight cases operated upon, saved thirty-six. At about the same time Apostoli began the use of electricity and succeeded so well in giving relief to symptoms that Keith himself, regardless of his wonderful results, almost entirely abandoned hysterectomy and devoted himself to the new fashion of the day. No two men in the profession enjoyed or deserved its confidence more than Apostoli and Keith, and for several years there has been anxious waiting to see the effect of this most potential and silent element in the treatment of this formidable disease. Neither of these honest, conscientious workers ever claimed to remove the growth, although in many cases it was accomplished during the course of the application of the remedy. Many of their disciples claimed much more in this direction, but time has failed to justify all the claims. Many of the leading surgeons of this and foreign countries had so little faith in any permanent results from electricity that they "kept the faith" in hysterectomy and continued their work, improving the technique, thus showing better and better results from year to year.

At the same time the profession have been more keenly alive to the dangers from allowing a patient to go on to the menopause. Not only is there much danger directly from loss of blood, but indirectly from general exhaustion, thus rendering them less able to battle against attacks from other and more acute diseases. Again we are fast learning that these tumors do not retain their benign character to the degree we had supposed and had carelessly accepted. Sarcomatous, cystic, calcareous and even malignant degenerations frequently take place. New growths are added to the old and the pressure in many cases excites peritonitis from which death not unusually results. The deaths from the electrical treatment figure quite prominently in the statistics, and reports of relapses among the cases classed as "cured" are by no means infrequent. When we add to all this the glaring fact that in spite of all these methods of relief and cure (?) the large majority of these women suffer for years, leading a life of invalidism, directly attributable to the foreign body, it seems to my mind that the highest "conservative surgery" is that which seeks to make the operation of hysterectomy a comparatively safe one. That this is being done and will be much better done in the near future, I have but little doubt. Among the Germans, Martin has recently reported a large number of cases, and the grand total shows as favorable results as for ovariotomy and laparotomy for other causes. In the

same paper he claims that he is able to show from good sources that many relapses are occurring in the cases pronounced cured by Apostoli and Keith.

For the past ten years I have been well satisfied that hysterectomy is the only proper "conservative surgery" for uterine fibroma, and that it can be made equally safe with that of ovariotomy. While removal of the uterine appendages and curetting has, in my experience, done more than all else in way of relief, they both fail to remove the tumor. I think it may be fairly claimed that the sentiment of the profession is fast setting strongly in favor of hysterectomy for uterine fibroids, as against all other methods. Homans has done most excellent work in this direction and certainly he is the peer of any man in the profession, in this or any country, in honesty of purpose, fidelity to his convictions, and skill in operative technique. He has tried other means, but gives preference to hysterectomy. Numerous other surgeons of eminence are adding largely to the list of favorable results.

The principal difference of opinion lies in the method of performing the operation, especially as regards treatment of the pedicle. Opinions are largely divided between the intra- and extra-peritoneal. Nearly all agree in making a pedicle of the cervix and either bringing it into the abdominal wound or dropping into the cavity. When the latter method is used, some cauterize by one of several chemicals, or the actual cautery. Others cover it by the peritonæum, thus practically shutting it off from the cavity and excluding any septic material that may possibly come from the wound or vagina. For the past ten years I have operated by the various methods, but for the most part have adopted, what seems to me a much simpler form than any I have known.

Believing, as I always have, that it is important to remove the entire organ (for obvious reasons), rather than to leave any portion, which may undergo some one of the various degenerations, so common in later life, I first tried Freund's operation, but found it so complex and difficult that after one or two attempts I gave it up.

In one case where I encountered some extensive adhesions, I found it necessary to cut little by little and use an over and over suture to control hæmorrhage and thus completed the operation in this way, removing the uterus entire. Since then I have commenced by ligating as much as possible of the broad ligament, by a strong catgut ligature on each side, then dividing between it and the uterus, controlling hæmorrhage from the uterus by hæmostatic forceps. I then proceed down, from this point, the entire depth of

the broad ligament, with an over and over suture of the same material, closing the folds of the ligament as I cut it from the uterine side. I do this generally with a strong curved needle, and as I approach the uterine artery I dip below the point that has been divided, thus securing within the suture the artery before division. At this time I divide the peritoneal covering of the uterus in front and behind and carefully dissect off until I reach the vagina, having separated the bladder and the utero-sacral attachments behind. These flaps in front and behind are easily held by forceps, until the attachments of the broad ligament on each side are completely removed and secured by the suture, which is then continued across the vaginal opening, by uniting the flaps of peritonæum. This closes the vagina and the pelvic cavity is entirely shut off from any septic influence. The most troublesome part of the operation consists in securing the uterine artery and dissecting off the anterior attachments of bladder and vagina, especially when the cervix is very long. Where the tumor involves the cervix the difficulty is much less to relieve the attachments. By this method the entire organ is removed and no pedicle left to give any anxiety—the patient is freed from her burden which she has borne so long and the future is full of hope, so far as freedom from suffering is concerned. In one case I had secondary hæmorrhage at the end of two weeks—proving fatal. The percentage of fatal cases in my own practice has been as small as in laparotomy for other causes.

With the improvement that necessarily comes from a larger experience, I feel very sure that with an operation that removes not only the tumor, but the uterus, completely, we have promise of a better treatment for uterine fibroids, than by any method that leaves a portion, which may give rise to septic infection, or become the seat of malignant disease.